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AUTHOR Young, Laura Throckmorton; And Others
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ABSTRACT

The Program in Human Sexuality (PHS), an outpatient mental health clinic in the University of Minnesota Medical School that specializes in sexuality-related dysfunctions, had received a number of patient complaints in late 1992 and early 1993 about therapeutic processes and business services. The proactive approach was to survey patients about all points of communication, make changes, and retest each year to determine whether improvements occurred and to find more improvements to make. A second part of the approach was to include an ongoing system whereby patients could comment at any time during the year. Accordingly, an exploratory study described, analyzed, and compared data from 188 patients in 1993 and from 215 patients in 1994. Response rate was 80% in 1993 and 86% in 1994--high response rates because the staff planned, communicated, and worked well together. Patients ranged in age from 18 years to 80 years. A Patient Satisfaction Committee was also put in place and developed a significant communication system with patients. The committee chair kept records of complaints--common complaints were about billing mistakes and gaps in communications. Based on the survey and committee activities, improvements were made, including offering additional therapy hours, hiring a clinic manager, refining standards to maintain confidentiality for patients, and becoming more patient oriented in general. A continuing study would help facilitate more improvements and might help PHS employees anticipate specific problems and make corrections before they become obvious to patients. (Contains 25 references, survey data, and survey forms.) (Author/NKA)

Patient Satisfaction:
A Study in Communication

By
Ms. Laura Throckmorton Young
Dr. Earl E. McDowell
Dr. L. David Schuelke

Abstract

The Program in Human Sexuality (PHS), an outpatient mental health clinic in the University of Minnesota Medical School that specializes in sexuality-related dysfunctions, had received a number of patient complaints in late 1992 and early 1993 about therapeutic processes and business services. The proactive approach was to survey patients about all points of communication, make changes, and retest each year to determine whether improvements occurred and to find more improvements to make. A second part of the approach was to include an ongoing system whereby patients could comment at any time during the year.

This investigation is an exploratory study that describes, analyzes, and compares data collected from patients in 1993 and 1994. After a literature review; it asks the research questions; describes the methods; offers the comparative analysis, quantitative and qualitative; and lists improvements. It concludes with limitations and suggestions for further research and continued improvement.

Introduction

The Program in Human Sexuality (PHS), an outpatient mental health clinic in the University of Minnesota Medical School that specializes in sexuality-related dysfunctions, had received a number of patient complaints in late 1992 and early 1993. Although other patients had complained, one relatively tightly knit group, gender dysphoria patients, was especially vocal about its disappointment in therapeutic processes and in business services, such as billing and insurance. Some patients had left PHS for therapy at other clinics and others had taken their concerns to the media. Some patients' expectations clearly were not being met, some did not seem to understand the processes. Although many of the complaints were not credible, enough of them were to justify a close, analytic look at the communication portion of delivering quality service. In some cases, simple communication about therapy or business practices would satisfy the patients, but PHS staff also wanted to make more proactive changes that would meet patients' expectations in a continuing communication effort requiring involvement by both patients and staff. The approach was to develop a cycle of communication in which PHS would survey patients about all points of interpersonal contact, make changes and retest each year to determine whether improvements occurred and to find more improvements to make. A second part of the approach was to include an ongoing system whereby patients could comment at any time during the year.

This research describes, analyzes, and compares survey data collected from patients in 1993 and 1994 and offers a sample of individual comments. The inverstigation concludes with limitations and suggestions for further research and continued improvement.

The goals for PHS staff would be to provide the maximum quality service possible to patients. To achieve that goal, the staff would need to listen to patients, plan the communication process, study the survey data, and implement improvements to their systems and continue the cyclic process to perfection. In late 1992 and early 1993, patients had already begun to express their dissatisfaction

with services so it seemed natural to build on that beginning by planning an annual survey and an ongoing communication process.

Patient Satisfaction Concepts and Research

Festinger's dissonance theory would lead one to deduce that patients want to think they made the right decision after they have chosen a therapist and begun work. In an effort to reduce that tension, they would consider the service better than others, continue to seek information about the service but tend to select information that supports their prepurchase perceptions, and seek the approval of other people (Wilkie, 1994).

Lerner's (1971) Satisfaction Ratio indicates wisdom in giving patients what they want.

Satisfaction = Achievement / Aspiration

Deming (1986) advises to meet and exceed customers' needs. Berry (1995) says to "surprise" customers with more than they expect, and Honeywell goes a step further to "delight" its customers. Because patient satisfaction has been directly linked to symptom reduction (Attkisson & Zwick, 1982; Carscaddon, 1990), PHS staff would want to use a direct approach to finding out what the patients wanted and figuring out how to give it to them, within physical, financial, and ethical reason. The literature helped to determine some questions to ask.

Therapists and Therapy

Three characteristics help to make an effective therapist: genuineness; ability to provide a nonthreatening, trusting atmosphere; and ability to empathize with their patients (Truax & Mitchell, 1971). Patients also place high value on therapists who "really care and want to help," and who are "easy to talk to, nonjudgmental, fair, and respectful" (Robinson, 1989). Because the emotional health of therapists is reflected in professional behavior, it is important to train therapists to be "warm, genuine, and empathetic" (Rudy et al., 1985). During the intake process, helpfulness, understanding, and empathy toward the client, making a special effort for those with poor prognoses, and making services readily available improve satisfaction (Schueman, et al., 1980).

Asking patients what their expectations are initially and throughout counseling so that their expectations and perceptions of the experiences can match

increases the likelihood of satisfaction (Friedlander, 1982). Using an information sheet to gather data about patients' expectations at the initial visit helps to expedite the process (Webster, 1992). Some studies compare patients' expectations with those of their therapists; other studies surveyed only therapists. Outcomes are related to satisfaction, and feedback of patients and therapists contribute to the patients' overall satisfaction (Fiester, 1979). Patients in another study indicated greater satisfaction with their therapeutic experiences than did their therapists (Bloom & Trautt, 1978). Another study found that patients placed greater importance on their relationship with their therapists, on the importance of meeting their goals, and on satisfaction with finishing tasks than did their therapists. They indicated a direct link between perceived alliance with their therapist and their satisfaction (Halstead et al., 1990), and patients who are psychologically distressed report more dissatisfaction (Greenley et al., 1982). Patients' confidence in therapists, positive therapeutic relationship, and the number of individual sessions also indicated greater satisfaction (Flynn et al., 1981). Patients also want their therapists to be easily accessible and prompt (Robinson, 1989). Therapists placed greatest satisfaction on whether they had communicated information to their patients' effectively. They also liked working with well-educated patients, being able to use special expertise, and applying technology to the treatments (Wertz et al., 1988). Research by Tracey (1989) encourages therapists to monitor the general satisfaction of their patients and use the feedback to measure treatment progress.

Business Systems

Several studies revealed advice for the business side of patient satisfaction. Some suggestions for managers follow: create the perception of quality service; promote satisfaction by changing aspects of service, communications, and delivery of services; and divide clients into logical target groups and measure their satisfaction in an ongoing system, implying a long-term commitment. Complaining clients may be managed by being supportive, listening, and responding appropriately (Moore, 1992). Organizations should make it acceptable for customers to complain and resolve the complaint on the first try (Slama & Celuch, 1994). Making excuses for errors contributes to the customers' distrust of the organization, and a response letter or financial compensation contribute to the customers' positive perceptions about the organization (Baer & Hill, 1994).

Support staff also play an important role in setting a professional and helpful tone in clinics (Robinson, 1989). Bureaucratic rigidity toward patients, duration of treatment, and conditions of termination also affect satisfaction (Greenley & Schoenherr, 1981; Friedlander, 1982).

Limitations were considered when PHS staff chose and designed two media with which to communicate with patients: the annual survey asks questions about important points of interpersonal communication and an ongoing form encourages complaints and praises. Questions for the survey were designed to reveal satisfaction levels in four general areas: therapy, psychiatric services, business systems, and overall. Qualitative questions requested comments about positive and negative aspects of patients' experiences at PHS. A comparative analysis of data collected would measure improvements each year. The research questions follow.

Research Questions

What do the patients think about the therapy they receive at the Program in Human Sexuality?

What do the patients think about the psychiatric services they receive at the Program in Human Sexuality?

What do the patients think about the systems necessary to doing business at the Program in Human Sexuality?

What do the patients think about overall performance of the Program in Human Sexuality?

What have been patients' positive experiences at the Program in Human Sexuality?

What have been patients' negative experiences at the Program in Human Sexuality?

How might the Program in Human Sexuality staff improve their services (psychotherapeutic, psychiatric, business) to their patients?

Did patients' sense of satisfaction improve one year later and if so how?

Did patients' sense of satisfaction deteriorate one year later and if so how?

Did patients in subprograms differ from year to year and if so how?

Procedures

Two surveys, in August 16-27, 1993, and August 15-26, 1994, were conducted and an ongoing communication system for complaints and compliments was implemented. The message, both implicit and explicit, from clinicians and staff to patients was that they cared about the patients and wanted to listen to their concerns. Clinicians and staff demonstrated a willingness to respond to every communication and to design systems that would make doing business at the Program in Human Sexuality (PHS) as easy and pleasant for patients as possible.

Permission to conduct the study was granted by the Committee on the Use of Human Subjects in Research, Office of Research and Technology Transfer Administration, University of Minnesota. The survey was held during a two-week period each year in the clinic as patients arrived for their appointments and left the clinic. Virtually all active adult patients would appear for appointments during any two weeks; attendance was usually high in August. The survey became an "event" as staff hung brightly colored, attention-getting messages around the clinic that encouraged patients to participate (Appendix A). A table with cookies, coffee, and questionnaires was set up in the reception area. All staff, therapists and support, encouraged patients to participate, assuring them that their responses would be anonymous and expressing staff's eagerness to know what they thought.

Population

The Program in Human Sexuality is an outpatient mental health clinic that specializes in sexuality-related dysfunctions. The respondents, all older than 18, were doing individual, couple or family, group therapy, or some combination. Most patients attended voluntarily although some were sex offenders sentenced by the court system to attend sessions. Some patients paid their own fees, but most relied on third-party payers. Disabled patients were accommodated. The patients' genders were female, male, and transgender; their ages spanned 18 to 80 years; and their length of time at PHS spanned from the first visit to seven years, six months. Sixty respondents indicated they had been attending sessions more than 12 months, but because the questionnaires were returned anonymously, staff could not tell whether they were repeat respondents. The respondents spent their time working in any or some combination of the following subprograms: Abuse Recovery, Gender Dysphoria/Transgender, Marital and Sexual Dysfunction, Compulsive Sexual

Behavior, Sexual Offender, Sexual Orientation, HIV Counseling, Sexual Harassment, and General Therapy. Some also had appointments to see a psychiatrist only or to have a psychological or physical evaluation only. Some attended a variety of seminars in addition to their therapy; topics included sexual orientation, gender dysphoria, intimacy, and sexual attitude assessment.

Questionnaire

The questionnaire was written with comments and suggestions from the entire staff and according to requirements by the human subjects committee. The cover page contained instructions; page two was the consent form, and pages three and four were the survey itself. The questionnaire was designed to elicit opinions about all points of communication contact. Categories of questions on the 1993 form covered overall satisfaction, satisfaction with therapists, and satisfaction with elements of doing business at PHS. The respondents' choices were on a seven-point Likert-scale of very dissatisfied to very satisfied; no, definitely not to yes, definitely; and very poor to excellent. An odd-number scale was chosen to relieve participants of making a positive or negative decision; feeling neutral about questions seemed as valid as satisfied or dissatisfied. A scale of five would have been as effective as seven; a seven-point scale was chosen to allow for an option to use more detailed data. The questionnaire also contained two open-ended questions requesting responses about positive and negative aspects of experiences at PHS. A demographic section was designed to code patients to subprograms, length of experience at PHS, and age and gender groups. In 1994, an additional question about psychiatric care was added with a non-applicable option. Also in 1994, the demographic section was refined to facilitate coding patients to subprograms (Appendices B).

Response Rates

The 1993 response rate was 80% of 235 patients who visited the clinic, 188 voluntarily completed the questionnaire. In 1994, the response rate was 86% of 251 patients, 215 voluntarily completed the questionnaires. The response rates both years were high for three reasons: 1) the questionnaires were distributed and collected at the clinic, where waiting patients had time to respond, 2) the tracking

system helped to maintain some certainty that all patients had been asked to complete questionnaires, and 3) the whole staff made a concerted effort to ask all qualified patients to respond. The response rate increased from 80% in 1993 to 86% in 1994 because one person took responsibility for and worked full time on data collection.

1993 and 1994 Survey Results
Comparative Analysis

The data on seven-point Likert scale were coded into three groups to facilitate discussion: numbers 1, 2, and 3 were coded to dissatisfied; number 4 was neutral; and numbers 5, 6, and 7 were coded to satisfied. The following tables compare percentages of satisfied patients for 1993 and 1994 with the positive and negative variances in percentages. The comparative discussion of the quantitative data will include changes of more than 3 percentage points. Neutral responses were not considered in this study.

Quantitative Responses

Overall services:

Question	1993	1994	Change
Satisfied with overall services	87%	89%	+2%
Satisfied with their ability to handle the problems that brought them to therapy	76%	74%	-2%
Would recommend the clinic to a friend or relative who needed help	90%	89%	-1%

Patients' satisfaction with overall services remained nearly the same.

Therapeutic services:

Question	1993	1994	Change
Satisfied with their therapists' ability to understand their problems	89%	90%	+1%
Satisfied with the caring and warmth they received from their therapists	88%	90%	+2%
Satisfied with the respect therapists expressed for the patients' opinions and feelings	90%	92%	+2%
Satisfied with their therapists' knowledge of sexuality issues	92%	89%	-3%

Patients' satisfaction with therapeutic services improved only slightly in 1994.

Business services:

Question	1993	1994	Change
Satisfied with the welcome received from the receptionist	77%	79%	+2%
Satisfied with the way the receptionist handled phone calls	79%	81%	+2%
Satisfied with the amount of time between arrival and session	77%	75%	-2%
Satisfied with the ease of making appointments	69%	80%	+11%
Satisfied with the availability of appointments	52%	66%	+14%
Satisfied with the way billing was handled	68%	59%	-9%
Satisfied with the reasonableness of fees	56%	51%	-5%
Satisfied with the way privacy was handled	91%	89%	-2%
Satisfied with the time between first phone call and first appointment	70%	82%	+12%
Satisfied with the intake person	80%	84%	+4%

This discussion of business-related systems will deal with improvements first, followed by areas that need continued work.

> Satisfaction among all patients with "availability of appointments" improved 14 percentage points, from 52% satisfied in 1993 to 66% satisfied in 1994.

Although all clinicians made an effort to be available for appointment times later in the day, when patients in 1993 said they preferred to arrive, percentages in two subprograms made a noticeable difference in the overall numbers: the Gender Dysphoria Program for 23 percentage points and the Marital and Sexual Dysfunction Program also for 23 percentage points. An 8 percentage point positive variance occurred also in the Sex Offender Program. Difficulty in attributing these variances to specific causes indicates the need for additional research.

> Patients were more satisfied in 1994 with the "amount of time between their first phone call to the clinic and their first appointment" by 12 percentage points, from 70% in 1993 to 82% in 1994.

The variances were greatest in the Gender Dysphoria Program at 19 percentage points and the Marital and Sexual Dysfunction Program at 33 percentage points. These variances require more research for explanation.

> Satisfaction with "ease of making appointments" improved 11 percentages points, from 69% in 1993 to 80% in 1994. The variances were greatest in the Gender Dysphoria Program at 25 percentage points and the Marital and Sexual Dysfunction Program at 24 percentage points.

The variances in these two factors might be attributed to both therapists and business office staff. Besides the therapists' efforts to be available when patients wanted to see them, the business office staff and their management organization worked together to design communication systems, tracking and computer, to accommodate the scheduling process. In addition, the increased awareness by the whole staff may have served to improve these factors. More research would be needed to arrive at more specific causes of these variances.

> Patients indicated an improvement in their "intake" experience by 4 percentage points, from 80% in 1993 to 84% in 1994.

Two subprograms also contributed to this variance: Gender Dysphoria Program at 22 percentage points and the Compulsivity Program at 24 percentage points. A significant change occurred in staffing at the Program in Human Sexuality (PHS) that might have attributed to this variance. The intake counselor left PHS and the position was absorbed by the therapists, who know their own subprograms best and can talk most knowledgeably to prospective patients. The

business office staff also was trained to handle the calls. Other explanations would require further research.

> Satisfaction with "the way billing is handled" dropped 9 percentage points in 1994, from 68% satisfied in 1993 to 59% in 1994.

Three subprograms contributed to this variance: Sex Offender Program at a positive 21 percentage points, Gender Dysphoria Program at a positive 11 percentage points, and the Compulsivity Program at a negative 38 percentage points. The strongest message about billing may have been sent to the Compulsivity Program because the subprogram coordinator also is the PHS director. Other more specific explanations would require follow-up research.

> Patients were less satisfied with "the reasonableness of fees" by 5 percentage points, from 56% in 1993 to 51% in 1994.

The variance for this category was rather undramatically distributed across four subprograms suggesting perhaps that PHS management re-examine fees. Because the overall variance was only 5 percentage points, management also might choose to leave fees unchanged. This factor also would need further research for a cause-effect explanation.

The comparative data show large percentage differences in some subprograms. The "overall satisfaction" factor showed only one very large variance among subprograms: the Gender Dysphoria Program at a positive 15 percentage points, and the factor labeled satisfaction with "therapist's caring and warmth" increased 17 percentage points also in the Gender Dysphoria Program. More research might determine the cause although the therapist-client relationship is confidential. One might speculate that the subprogram coordinator's concerted effort to improve his numbers was a contributing factor. PHS Director Eli Coleman, Ph.D., (personal communication, August 1995) offered that the positive changes in the Gender Dysphoria subprogram may be attributed in part to an effort to improve communication about the subprogram's attributes such that patients who wanted other services or therapeutic guidelines could decide to leave for other therapeutic options. Some patients did leave; the ones who stayed seemed more satisfied in general. Conflicting variances concerning reception on arrival at the clinic and by phone might be attributed to a transition in receptionists during which a wide variety of people handled both in-person and phone communication. The

factor called "welcome received upon arrival" received a positive 11 percentage point variance in the Marital and Sexual Dysfunction Program, a negative 3 percentage points in the Sex Offender Program, a positive 2 percentage points in the Gender Dysphoria Program, and a positive 8 percentage points in the Compulsivity Program. The category called "the way my phone calls are handled" also received a mixed response: negative 15 percentage points in the Marital and Sexual Dysfunction Program, positive 1 percentage point in the Sex Offender Program, a positive 17 percentage points in the Gender Dysphoria Program, and a positive 9 percentage points in the Compulsivity Program. Additional research would be required for substantive explanations.

Qualitative Responses

The qualitative comments were coded into categories that represented their similarities. Comments that fell into more than one category were coded to the group that seemed to represent the essence of the comment. If the comment did not seem to have one main theme, it was coded to the group that contained the comment's first entry. If the first entry was unclear, it was coded to the group that contained the comment's second entry. Although they were coded the same way each year, the 1994 data produced some new categories and did not use some 1993 categories. The following tables show the percentage of responses in each category for 1993 and 1994 with the changes. The comparative analysis will deal with variances of more than 5 percentage points.

Positive comments:

Of 188 patients who completed questionnaires in 1993, 138 or 73% wrote positive comments in response to the question that asked: "What are some of the most positive aspects of your experiences at the Program in Human Sexuality/University Mental Health? What did you particularly like about your experiences here?" The responses were coded as follows. Of 215 respondents in 1994, 161 or 75% wrote positive comments. Responses in 1994 increased only slightly. A comparative summary follows.

Comment Category	1993	1994	Change
Liked group membership, networking with other members, and the related therapy	13%	9%	-4%
Felt therapists were easy to talk to, were non-judgmental, respectful, fair, and friendly	12%	8%	-4%
Liked their progress in therapy, being able to get to the core of their problems and manage them better than they had before treatment	12%	6%	-6%
Valued therapists' special expertise in human sexuality	11%	7%	-4%
Felt therapists really care and want to help, were sensitive, kind, and had a genuine interest	11%	20%	+9%
Valued their new ability to understand and accept themselves	10%	7%	-3%

Both larger variances in the table above seem to support the quantitative data. The category titled "liked progress in therapy," showed a negative change and the category titled "felt therapists really care and want to help," showed a positive variance. Why patients feel they do or do not make progress in their therapy cannot be generalized to a group because therapy is individual and confidential. Further research would be needed to determine a correlation between the quantitative and qualitative data, but one might speculate that the Gender Dysphoria group supported its quantitative ratings with positive comments about the therapist's caring and warmth.

Negative comments:

Of 188 patients who completed questionnaires in 1993, 112 or 60% wrote negative comments in response to the question that asked: "What are some of the most negative aspects of your experiences at the Program in Human Sexuality/University Mental Health? If you could change anything, what would you change?" Of 215 respondents in 1994, 105 or 49% wrote negative comments, a negative variance of 11 percentage points in responses.

Comment Categories	1993	1994	Change
Complained about the availability and the ease of making appointments and appointments canceled or postponed by the clinic	28%	21%	-7%
Had problems with insurance and billing	12%	21%	+9%
Wanted more structure, clarity, and goal orientation in their therapy	12%		n/a
Said staff lacked human qualities, such as caring and warmth and trust and support	10%	13%	+3%
Said therapy was too expensive	9%	12%	+3%
Said therapy process was too long		8%	n/a

Two variances were large enough to consider in the group of negative comments. The negative variance of 7 percentage points in the category "complained about the availability and the ease of making appointments" indicates an improvement for 1994 and the positive variance of 9 percentage points in the category "had problems with insurance and billing" indicates the necessity for more work by PHS staff. Both variances are similar to the attitudes patients expressed in the quantitative data, but more research would be necessary to determine correlations and specifics.

Other Efforts Toward Patient Satisfaction

A Patient Satisfaction Committee, whose members were from the faculty, business office staff, and academic support staff, began in the Fall of 1993. The group met every month to discuss responses to patients' individual comments, prioritize comments and ideas for improvements generated by the survey, and to prioritize and implement new ideas. The group also established quarterly all-staff meetings to discuss survey results and development of new communication systems and procedures toward improved services.

Ongoing communication:

The Patient Satisfaction Committee developed a significant communication system with patients that would be available throughout every year. It was named Complaints and Praises and a form and envelopes, facilitating anonymity, were made available to patients in trays near the business office windows. The form provided space for the date a problem occurred, a description of the problem and people involved, and suggestions about how the situation could have been handled better. The form also allowed space to describe a positive occurrence and how it was handled well. Names, addresses, and phones were optional but when supplied, the proper PHS employee could respond directly about how the situation was resolved. The chair of the Patient Satisfaction received all of the Complaints and Praises forms and referred each to the appropriate employee to investigate the situation and respond. She responded herself to complaints that did not obviously "belong" to anyone. She was meticulous about keeping records separate from patient files and confidential, and she followed up in every case to be certain that the patients were reasonably satisfied with the results. Common complaints were about billing and insurance communications and records, canceled appointments on short notice, miscommunications, gaps in communications, unclear business systems, and errors. Requests were for quiet timers in the group rooms and updated credit-card-checking equipment, among others. Sometimes simple apologies were delivered, and where beneficial, new communications systems were written, clarified, or updated.

Other improvements:

Based on the Survey responses and on the Complaints and Praises system, the following improvements contributed to the patient satisfaction effort. Although the patients may not have asked specifically for some of the changes, staff made them sometimes as an indirect solution to a problem or in anticipation of what the patients would need sometime in the future, as Deming would suggest.

> Offered additional therapy hours for patients, especially later in the day

> Hired a clinic manager

> Revised a "no-show" policy for patients who don't show up for appointments and made the policy consistent for therapists as well

> Reorganized reception and the business office, physically and functionally, and added staff

> Refined the beeper system for therapists on call to clarify who was on call and added prescribing psychiatrists to a second rotation system

> Reduced academic support staff and increased research assistants to change expertise and improve efficiency

> Changed therapeutic session start times to include half hour beginnings to facilitate better patient flow past the business office

> Wrote a procedure to deal with disgruntled, argumentative, or dangerous patients

> Set standards for patient files and their contents

> Refined standards to maintain confidentiality for patients

> Refined system to file, collate, and track patients' psychological testing

> Redesigned many forms to more attractive and user-friendly formats

> Moved all forms to a more convenient and efficient location

> Bought quieter timers for group therapy rooms

> Updated credit-card equipment

> Became more patient oriented in general

> Cleaned and organized the library and supply room for greater efficiency and clinic kitchen, which is open to patients.

> An additional improvement in 1994 was a Report Card that communicated some of the survey results to respondents. The goal was to tell them what the group as a whole liked about services and what the PHS staff would be working on first as a result of patients responses on the questionnaires.

Suggestions for Further Research

The purpose of this research project was to open communication between patients and employees in two ways: one, to provide an assessment of how satisfied or dissatisfied patients were and in what ways and two, to provide an ongoing method of dealing with specific problems as they arose. The present communication techniques fulfilled those goals quite well, but additional or different information would facilitate more detailed and specific ideas for continued movement toward total patient satisfaction.

A continuing study would help facilitate more improvements, as Deming might recommend. Such an ongoing study would indicate trends that might help PHS employees anticipate specific problems and make corrections before they become obvious to the patients. Maintaining a general awareness among employees also would help to generate more ideas and enthusiasm toward the patient satisfaction goal. A study that asks patients to rank the importance of some issues would help PHS employees prioritize improvements. A comparison study of therapists and clients and staff and clients would identify differences in expectations and perceptions (Berry, 1995) and help employees and patients work to dissolve patients' dissonance. Academic support staff should be included in the staff surveys to get a fresh perspective from those who are only indirectly involved with patients. Opinions of former patients, who have finished therapy or who have gone elsewhere for their therapy might be more free from bias than those who remain at PHS because they perceive reduced risk or because they no longer deal with post-purchase dissonance issues. Why patients go to other clinics for therapy would help PHS employees prioritize improvements. Referral sources could be asked what kinds of patients they send to PHS and why, so that PHS staff could evaluate differences in perceptions and expectations and perhaps persuade referral sources to send more or different patients. More specific questions, quantitative and qualitative, would help determine more actionable problems and solutions. For example, patients were not especially satisfied with their psychiatric services but no space was given for comments about why. In the cases of patients who were especially disgruntled with billing and insurance systems, more specific information is necessary to get to the core of the problem. One possibility, without lengthening the questionnaire significantly, would be to leave a space after the quantitative questions encouraging respondents to elaborate about any of the questions with scaled responses. Another way to deal with this kind of issue would be to identify several areas to discuss in a focus group of willing patients. PHS staff also might want to consider the neutral responses in the quantitative data. If the neutral responses were considered cases of not satisfied patients, some messages for improvement might be found. The most positive variances in the 1993 and 1994 surveys were in the Gender Dysphoria and the Marital and Sexual Dysfunction subprograms. Focus groups of those patients might indicate what exactly the

coordinators and their staff are doing especially right. Key throughout the data-gathering processes that PHS chooses is communicating the resulting information to all staff.

Recommendations for Continued Improvement

PHS accomplished the communication and quality improvement goal it set out to achieve. It surpassed expectations regarding the response rate and high evaluations of its patients. The statistics in 1994 showed improvement overall and great improvement in some areas. The qualitative comments substantiated some of the statistics and served to facilitate additional, specific improvements. The Complaints and Praises forms also facilitated specific improvements. After a large staff downsizing, PHS is a rather small and its full-time staff is stable, but it has a number of student workers whose schedules change each quarter and who turn over rather rapidly, which complicates the communication process. To ensure stable and reliable services to patients, the following are advisable:

> Continue the present path of improvement using annual surveys and the complaints and praises communication system. More specific questions about therapy and business systems on the questionnaires would be useful.

> Work with the University to upgrade the scheduling systems. A new computer system and more user-friendly and flexible software would help staff make appointments and track them, filling in patients where others have canceled.

> Work with the management firm to upgrade billing systems. Communication via computer would speed processes that now frustrate patients.

> Work with third-party payers on payment systems. Communication via computer also would speed insurance paperwork and other information processes.

> Train staff carefully as new systems are installed.

> Document all systems, creating a user manual for PHS that would accommodate changes in staff. It would help train new people and those who fill in while others are on vacation. The user manual would also facilitate cross training, especially necessary because staff is small.

> Standardize and update all forms to user-friendly formats. Some patients perceive the handouts and educational materials to be old and out of date.

Many are old, but they are very useful and classic in content. If they were attractively designed and looked fresh, patients might feel better about using them. Standardization in design with the PHS logo would help patients to identify the materials with the clinic and facilitate their efficient use.

> Hold monthly all-staff meetings to anticipate patients' needs for a proactive approach to satisfaction. Design new systems, repair old ones, and plan for approaching large projects such as grants, contracts, seminars, and special events.

> Close the communication gap between therapists and support staff.

Conclusions

This study, even with its limitations, served the PHS staff well in its endeavor to increase patient satisfaction through improved communication and systems. The study produced a high response rate primarily because the staff planned, communicated, and worked well together, and it received a high evaluation for two probable reasons: Because evaluations for this kind of service tend to be high as discussed above and because therapy received at PHS is of high quality; clinicians are highly qualified and experienced, and they take great pride in their work and expertise. Support staff has stabilized and continues to improve and produce very well. Their continued success toward providing quality service to their patients include all staff members in the communication process.

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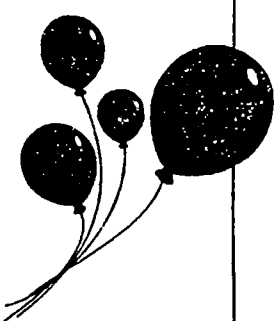
PROGRAM IN HUMAN SEXUALITY (PHS)
and
UNIVERSITY MENTAL HEALTH (UMH)

PATIENT SATISFACTION SURVEY

We are conducting our Annual Patient Satisfaction Survey (adults only). Please help us improve our clinic by answering some questions about the services you and/or your family received here. We are interested in your honest opinions. Please answer **ALL** the questions. We also appreciate your comments and suggestions.

Please fill out this form TODAY before you leave the clinic and return it to one of the specially marked bins in the lobby or by the Business Office.



Please fill out only ONE survey.
Thank you for your time. Help yourself to refreshments.

PROGRAM IN HUMAN SEXUALITY (PHS)
and
UNIVERSITY MENTAL HEALTH (UMH)

PATIENT SATISFACTION SURVEY

Consent Form

You are invited to be in a Patient Satisfaction study at Program in Human Sexuality/ University Mental Health. We are asking all of our adult patients who have appointments in the next two weeks to participate. We ask that you read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by the program in Human Sexuality/Department of Family Practice and Community Health, University of Minnesota Medical School.

The purpose of the study is to improve the way we communicate and do business with our patients. We want to know how to make patients' visits at PHS/UMH easy and positive.

If you agree to be in this study, we would ask you to: fill in the survey and put it in the receptacles marked for surveys.

This study has no physical or psychological risks. Your answers will be anonymous: there is no way we will know which survey you filled out. The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be kept in a locked file; only the researchers will have access to the records.

Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota or the Program in Human Sexuality or University Mental Health. If you decide to participate, you are free to withdraw at any time without affecting those relationships. You may skip any question you wish.

The researchers conducting this study are Laura Young and Bean Robinson. If you have any questions, ask the business office staff to contact one of the researchers.

Today's Date _____

1. Overall Satisfaction		**Very dissatisfied** ⟷			**Neither** ⟷			**Very satisfied**
My satisfaction with the **OVERALL SERVICES** I (or my family) am receiving is:		1	2	3	4	5	6	7
2. Problem Improvement								
My satisfaction with my ability to **HANDLE THE PROBLEMS** that brought me to therapy is:		1	2	3	4	5	6	7
3. How Satisfied I Am with My Therapist(s):								
① understanding of my problems.		1	2	3	4	5	6	7
② caring and warmth.		1	2	3	4	5	6	7
③ respect for my opinions and feelings.		1	2	3	4	5	6	7
④ knowledge in the special area of sexuality.		1	2	3	4	5	6	7
4. How Satisfied I Am with the Treatment I Received from the PHS/UMH psychiatrist: (If not applicable, circle N/A.)	N/A	1	2	3	4	5	6	7
5. Would You Recommend Our Services?		**No, definitely not** ⟷			**Not sure** ⟷			**Yes, definitely**
If a friend or relative needed help, would I recommend the Program in Human Sexuality?		1	2	3	4	5	6	7
6. Satisfaction with Other Clinic Services: **How would you rate the following?**		**Very poor** ⟷			**Neither** ⟷			**Excellent**
① The welcome I receive from the receptionist upon my arrival.		1	2	3	4	5	6	7
② The way my phone calls are handled by the receptionist.		1	2	3	4	5	6	7
③ The amount of time I have to wait to see my therapist, once I arrive.		1	2	3	4	5	6	7
④ The ease of making appointments.		1	2	3	4	5	6	7
⑤ The availability of appointments.		1	2	3	4	5	6	7
⑥ The way my billing is handled.		1	2	3	4	5	6	7
⑦ The reasonableness of the fees compared with similar services elsewhere.		1	2	3	4	5	6	7
⑧ The way my privacy is handled.		1	2	3	4	5	6	7
⑨ The amount of time between my first phone call to the clinic and my first appointment.		1	2	3	4	5	6	7
⑩ The Intake person who set up my initial appointment(s).		1	2	3	4	5	6	7

PLEASE TURN PAGE

7. What are some of the **MOST POSITIVE ASPECTS** of your experiences at the Program in Human Sexuality/ University Mental Health? What did you particularly like about your experiences here?

_____

_____

_____

8. What are some of the **MOST NEGATIVE ASPECTS** of your experiences at the Program in Human Sexuality/ University Mental Health? If you could change anything, what would you change?

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOU OR YOUR FAMILY SO WE CAN BETTER UNDERSTAND YOUR EXPERIENCES AT THE PROGRAM IN HUMAN SEXUALITY/UNIVERSITY MENTAL HEALTH.

9. Which of the following services have you or your family received here at the Program in Human Sexuality/ University Mental Health? **(CIRCLE ALL THAT APPLY)**

① Evaluation/Assessment, ONLY
② Individual Therapy
③ Couple or Family Therapy
④ Group Therapy. Name of group(s) _____
_____
_____
⑤ SAR (Sexual Attitude Reassessment Seminars)
⑥ Man-To-Man Seminars
⑦ Gender Dysphoria/Transgender Seminars
⑧ Sexual Medicine Exam
⑨ Psychiatric/Medication Evaluation and Monitoring
⑩ General Physical Exam
⑪ Medical Visit for Hormone Therapy
⑫ Other. Please describe: _____

10. Which of the following programs have you or your family received service from here at the Program in Human Sexuality/University Mental Health? **(CIRCLE ALL THAT APPLY)**

① Abuse Recovery Program
② Gender Dysphoria/Transgender Program
③ Marital and Sexual Dysfunction Program
④ Compulsive Sexual Behavior Program
⑤ Sexual Offender Program
⑥ Sexual Orientation Program
⑦ HIV Counseling Program
____ Check here if Ryan White HIV Program
⑧ General Therapy/Counseling Program
⑨ Sexual Harassment Program

11. I have been in therapy at the Program in Human Sexuality/University Mental Health for about _____ months and attended about _____ sessions.

12. My current age is _____ years.

13. My sex is: **(MARK THE NUMBER THAT APPLIES)**

① Female
② Male
③ Transgender

THANK YOU FOR TAKING TIME TO COMPLETE THIS SURVEY!